County of Los Angeles
CHIEF EXECUTIVE OFFICE
713 KENNETH HAHN HALL OF ADMINISTRATION
LOS ANGELES, CALIFORNIA 90012
(213) 974-1101
http://ceo.lacounty.gov

WILLIAM T FUJIOKA
Chief Executive Officer

September 10, 2007

To: Supervisor Zev Yaroslavsky, Chairman
Supervisor Gloria Molina
Supervisor Yvonne B. Burke
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

SACRAMENTO UPDATE

Health Care Reform

AB 8 (Nuñez, Perata) passed the Senate today by a vote of 22 to 17. It is expected that the Assembly will follow suit shortly, and then send the bill to the Governor's desk. It is widely believed that the Governor will veto AB 8 and then call the Legislature into special session to deal with health care reform.

Nevertheless, there is continuing dialog between the Governor and Legislative leaders. Among the more difficult hurdles are: 1) counties and public hospitals have insufficient information to assess the impact on a health care safety net that is already underfunded; 2) labor unions oppose the idea of an "individual mandate" which requires employees to purchase health coverage under the Governor's plan; and 3) AB 8 places the burden to finance the proposal on employers and hospitals which is not the "shared responsibility" envisioned by the Governor. Complicating the outlook for reform is that while legislators in both houses and on both sides of the aisle support the goal of improving California's broken health care system, they have strong doubts on how to accomplish it, how it should be financed, and whether something this complex should be rushed.

One of the factors contributing to forward movement on health reform is that on Thursday, September 6, 2007, the California Hospital Association's (CHA) Executive Committee voted to "conceptually" endorse a $1.7 billion fee on hospitals, which is a key component of the Governor's health care reform plan. Under the provisions of CHA's conceptual agreement with the Administration, public hospitals would be obliged to pay a fee of $600 million. These monies, when matched with federal funds, would generate about $4.0 billion, which would be returned to hospitals based on how many indigent patients are treated. According to the California Association of Public Hospitals (CAPH), the private hospitals will gain "an estimated net benefit of $1.7 billion under the Governor's reform proposal."

The Administration estimates that $500 million would be returned to public hospitals. However, the analysis used to produce the estimate is incomplete and misleading. The County Department of Health Services and CAPH actually believe the gain would only be a small fraction of that amount. We are continuing to work with the Administration to develop a more accurate estimate of the financial impact.

However, the hospital fee may be construed to be a "tax" which would require voter approval. The latest information suggests that because of the possibility that this may be considered to be a tax, that portion of the reform plan will be placed before the voters as a ballot initiative, because it would not garner the required two-thirds vote of the Legislature. Assembly and Senate Republicans remain opposed to any "tax" on hospitals or fees on employers to finance health care reform.

The September 5, 2007 amendments to AB 8 specified that counties are the employer of record for In-Home Supportive Services (IHSS) providers for purposes of meeting the AB 8 health spending requirement. Because of that provision, the California State Association of Counties (CSAC), the Urban Counties Caucus, the County Welfare Directors Association, the County Mental Health Directors Association, and the County Health Executive Association of California sent a joint letter on September 6, 2007 to oppose AB 8 unless amended to increase State financial participation to offset the cost to counties for IHSS worker coverage. Attachment I contains the letter sent by CSAC and its affiliate organizations indicating their concern that this approach would strain realignment funding and have a long term impact on the revenues available for health, mental health, and social services programs in California.

AB 8 was further amended on Friday, September 7, 2007. Those amendments appear to be at the request of SEIU and deal with the issue of premium assistance for low income workers who would be compelled to buy coverage under the reform plan.

In addition, CAPH sent a letter to the Governor, Senate pro Tem, and Assembly Speaker on Friday, September 7, 2007 expressing continuing support for health reform,

stressing the significance of public hospital systems in California's health delivery system, and expressing concern that the "current proposals do not provide the components necessary to ensure stability for public hospital systems and their essential services." The letters also questioned the $500 million estimated gain to public hospitals attributed to the provider fee structure agreement between the Governor and CHA and offered several necessary provisions that must be included in health reform. The two letters included in Attachment II, also contain CAPH's analysis of the aggregate impact of the Governor/CHA proposal on public hospitals.

On Friday, it was also brought to our attention that CHA had discovered a technical error in the assessment of the impact of the provider fee on individual private hospitals. It is expected that the results of the corrected model will be available shortly. The provider fee model developed for CHA does not include any assessment of the impact of the fee on public hospitals.

Status of County-Sponsored Legislation

County-sponsored AB 800 (Leiu), which would amend the Water Code to clarify the requirement that the local public health officer be immediately notified in the event of a sewage spill, passed the Senate on September 4, 2007 by a vote of 24 to 12, and now proceeds to the Governor.

County-sponsored SB 959 (Romero), which would authorize boards of supervisors to permit involuntary home detention with electronic monitoring when faced with jail overcrowding, passed the Senate on September 5, 2007 by a vote of 33 to 2, and now proceeds to the Governor.

Status of County Advocacy Legislation

County-opposed AB 338 (Coto), as amended on September 6, 2007, would allow injured workers to receive temporary disability payments over a five-year period rather than the current 104-week period. AB 338 would not increase the existing limit of 104 payments per claim. CEO Risk Management staff indicates that the September 6, 2007 amendments that reduce the number of total payments from 156 to 104 per claim and the removal of the formula to extend the claim period based upon delays by the employer are appropriate and address the County's major concerns. As such, **our Sacramento advocates will remove the County's opposition to AB 338 and adopt a neutral position**. AB 338 was approved by the Senate Appropriations Committee on August 31, 2007 by a vote of 10 to 7, and has moved to the Senate Floor.

County-opposed SB 942 (Migden), as amended September 6, 2007, would modify the eligibility of an injured employee to supplemental job displacement benefits from

60 days after the termination of temporary disability indemnity payments to 60 days after the disability becomes permanent and stationary. The bill also would provide the employee 60 days to accept an employer's offer of regular or modified work. This bill is now co-joined with AB 1636 to avoid issues related to chaptering. CEO Risk Management staff indicates that the September 6, 2007 amendments which remove the presumption of employer discrimination if an injured employee is not reinstated within five working days of a release by a treating physician are appropriate and remove the County's major concerns. As such, **our Sacramento advocates will remove the County's opposition to SB 942 and adopt a neutral position**. SB 942 passed the Assembly Insurance Committee by a vote of 7 to 3 and has moved to the Assembly Floor.

We will continue to keep you advised.

WTF:GK
MAL:IGA:acn

Attachments

c: All Department Heads
Legislative Strategist
Local 721
Coalition of County Unions
California Contract Cities Association
Independent Cities Association
League of California Cities
City Managers Associations
Buddy Program Participants

CALIFORNIA STATE ASSOCIATION OF COUNTIES

URBAN COUNTIES CAUCUS

CALIFORNIA MENTAL HEALTH DIRECTORS ASSOCIATION

COUNTY HEALTH EXECUTIVES ASSOCIATION OF CALIFORNIA

CWDA

COUNTY WELFARE DIRECTORS ASSOCIATION

September 6, 2007

The Honorable Fabian Núñez
Speaker, California State Assembly
State Capitol, Room 219
Sacramento, California 95814

Re: AB 8 (Núñez and Perata): Health care.
As amended September 5, 2007 – OPPOSE UNLESS AMENDED
Senate Second Reading File

Dear Speaker Núñez:

California counties deeply appreciate your leadership on health reform over the last year. Counties – as employers, providers, and payers of health care – are supportive of efforts to expand health coverage. We are supportive of the goals of AB 8 – to reduce the number of uninsured, working Californians.

Regrettably, the latest amendments to AB 8 cause counties great concern. The undersigned county associations must respectfully oppose the provisions that specify that the employer of record for In-Home Supportive Services (IHSS) providers is the employer for purposes of meeting AB 8's health spending requirements. Counties are NOT opposed to providing IHSS providers with health benefits; our concerns are the financing of these provisions.

Counties are concerned that increased IHSS costs will further strain Realignment funding and have long-term ramifications on the revenues available for health, mental health, and social services programs in California.

Currently, counties pay a share of cost for IHSS administration, IHSS services, and IHSS provider wages and benefits. Realignment funds – a combination of sales tax and vehicle license fees – are used to match state and federal funds for the program. Under current agreements, many counties will not meet the 7.5 percent health-spending threshold required under AB 8 for IHSS providers. Therefore, county spending for health benefits will have to increase. Because of the structure of Realignment, increased spending on IHSS will have negative impacts on other social services, health, and mental health programs.

The Realignment accounts are interrelated. Increased spending on one program can affect all funding available for health and welfare programs. For example, much of the growth in the Realignment social services caseload account since 2000 has been due to growth in the IHSS program. During the time that IHSS costs have grown, there has been no sales tax revenue available under Realignment for health and mental health growth.

Essentially, social services caseload and costs are growing at a larger rate than sales tax revenue. Because the revenue is insufficient to meet costs, counties are currently owed approximately $60 million for 2006-07 social services caseload. Based on sales tax projections, it appears that the social services account will continue to be in arrears for the foreseeable future, much less leave any revenue to provide funding growth for health or mental health.

AB 8 would cause expenditure growth in the IHSS program, in turn increasing social services growth and ultimately making it more likely that the health and mental health accounts continue to be denied sales tax growth revenue. AB 8 will have long-term ramifications on the future revenue available for health, mental health and social services in this state.

Counties are currently struggling to overmatch a variety of social services programs – child welfare, IHSS, Food Stamps – in part due to the State's failure to fund over $800 million in actual costs for human services programs. It is unreasonable to expect counties to continue overmatching critical programs *and* to increase health costs for IHSS. If counties increase health expenditures for IHSS providers it will come at the direct expense of other services, such as child welfare and mental health.

Counties recommend that AB 8 be amended to recognize that the current Realignment structure cannot bear all of the increased health costs for IHSS providers stemming from AB 8.

Counties have also identified a number of technical questions and concerns with how AB 8 affects IHSS. It will be imperative to answer these questions as we move forward.

To what extent would Federal Medicaid or SCHIP matching funds be available to finance part of the cost of medical assistance provided to IHSS providers?
Under IHSS, the federal, state, and county governments share the cost of wages and benefits provided to IHSS providers many – if not most – of whom have incomes that would be low enough to qualify for Medi-Cal and/or SCHIP/Healthy Families under AB 8. Federal law prohibits federal funds from being used to match other federal funds (including Medicaid and SCHIP). Therefore, it is highly questionable that any Federal IHSS funds could be used to help pay for health benefits to providers whose benefits also would be financed, in part, by Medicaid and/or SCHIP funds.

Would the existing federal IHSS wavier need to be renegotiated?
The current waiver, which expires on July 31, 2009, includes a per capita limit for Medicaid eligible participants as well as annual expenditure targets. If actual federal financial participation (FFP) claimed by the State exceeds the expenditure targets, then the State must submit a corrective action plan for federal approval. The State and County would have to finance the full cost of any health benefits that exceed either the per capita cost limit or overall expenditure limit for the waiver.

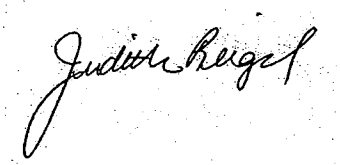
If public authorities are the employer, what happens if a county is at the maximum rate for state participation in wages and benefits?
If a county is at $11.50 for wages and $.60 for benefits, there are no additional state funds available for match. Would counties be responsible for the entire difference between $.60 per hour and 7.5%? One option to allow for additional state sharing would be to increase the state cap on sharing for health benefits. Would federal matching dollars be available?

California counties are very concerned about the impacts of AB 8 on Realignment funding. For these reasons, we must oppose AB 8 unless amended to increase state financial participation. Our associations remain available to work with your office on health reform as it impacts counties. Please do not hesitate to contact any of us if you have further questions. Thank you.

Sincerely,

Paul McIntosh Casey Kaneko Patricia Ryan

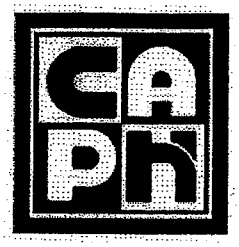
Paul McIntosh	Casey Kaneko	Patricia Ryan
Executive Director	Executive Director	Executive Director
CSAC	UCC	CMHDA



Judith Reigel
Executive Director
CHEAC

Frank Mecca
Executive Director
CWDA

cc: The Honorable Don Perata, Senate President Pro Tempore
Sumi Sousa, Consultant, Speaker's Office
Scott Bain, Consultant, Speaker's Office
David Panush, Consultant, Senate President Pro Tempore Don Perata
Ana Matosantos, Legislative Deputy, Governor's Office



CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

September 7, 2007

The Honorable Arnold Schwarzenegger
Governor, State of California
State Capitol
Sacramento, CA 95814

RE: Health Care Reform Proposals for Governor's Proposal, AB 8 (Núñez, Perata)

Dear Governor Schwarzenegger:

California's public hospital systems share your goal of improving coverage and access to care for millions of low income and uninsured Californians. Though just 6 percent of all hospitals statewide, California's public hospitals provide roughly half the hospital care for the state's 6.5 million uninsured. In addition, public hospital systems provide essential health care services for entire communities, including 60 percent of all top-level trauma centers, nearly 45 percent of all burn units, and training for 45 percent of all doctors in the state. Public hospital systems also provide roughly 11 million outpatient visits a year.

Given the essential services provided by public hospital systems, health care reform can only achieve the goals of improving care and access if it is structured to ensure that all Californians can access the critical services that public hospital systems provide.

We are concerned that the current proposals do not provide the components necessary to ensure stability for public hospital systems and their essential services. We offer the following comments in an effort to both provide guidance and solutions as to how to move toward that stability as well as to issue caution of the effects of an inadequate proposal.

Questionable Analysis of Impact to Public Hospital Systems
Your Administration has asserted that public hospital systems stand to gain $500 million from the provider fee and increased Medi-Cal rates. *The analysis that lies behind this figure is incomplete.* It does not reflect significant costs to counties and public hospital systems which would reduce the projected net benefit. We are also concerned that the figure is inadequate to achieve the goals of public hospital systems to maintain viability and to transform their systems of care to be competitive in a reformed health care system, particularly in light of the current underfunding of the health care system. Please see the attached chart that demonstrates a likely impact to public hospital systems of between $52 million and $323 million, depending on whether or not a Local Coverage Option is included (described below.) This figure reflects CAPH's comprehensive analysis of the full components of health care reform and the likely impact to public hospital systems.

As the Legislature draws closer to a final health care reform package, it is essential that the following components be included:

- **Medi-Cal Rates that Reflect the Full Cost of Providing Care**

The historical underfunding of the Medi-Cal system in California must be addressed in order to improve access to care for low income Californians. Public hospital systems' current reimbursement of 50 cents of every dollar simply perpetuates these access issues. Rates for public hospital systems must be paid at

70 Washington Street ■ Suite 310 ■ Oakland, CA 94607 ■ 510.874.7100 ■ 510.874.7111 (fax)

current and future full cost for inpatient and outpatient services, both under fee-for-services and managed care.

The Administration has indicated verbally that its proposal includes full cost rate increases. However, we have not seen anything in writing either verifying this component or demonstrating its funding source.

- **Expansion of Childless Adults Through Local Coverage Options (LCO's) for Childless Adult Expansion**

Health care reform provides an opportunity to transform the current health care delivery system into a coordinated system of care that manages people's medical conditions and reduces inefficient use of emergency rooms. But at the same time, a reformed health care system must support safety net providers, including public hospital systems.

These twin goals can be met through a structural mechanism to both expand coverage and support public hospital systems. CAPH supports a coverage expansion of childless adults in which these newly covered patients would enroll exclusively in Local Coverage Options -- transitional, county-based coverage programs using a limited network of public hospital systems and community clinics, and other providers for medically necessary services that are not available in the aforementioned network of providers. The creation of LCO's would provide public hospital systems with a more viable patient base and with additional revenue needed to assure and improve care for all who rely on their services. Since entire communities, indeed, rely on their public hospitals for essential services, ensuring an ongoing revenue source is critical for all residents.

- **Reasonably Constructed County Share of Cost**

Public hospital systems already operate under serious financial constraints; therefore a proposed county contribution for health care coverage should be considered only as part of a comprehensive health care reform package that includes support for public hospital systems, with full cost Medi-Cal rate increases and an expansion of coverage for childless adults under 100% FPL. In the context of such a comprehensive reform package, a financial contribution from counties is possible, **ONLY IF** it is:

  - Retrospective so that counties are not asked to fund a system upfront based on projections;
  - Based on actual cost reductions with consideration of remaining fixed costs and the costs of treating those who remain uninsured; and
  - Structured in a way that takes into account both the State's need to fund a health care reform system and counties' need to respond to possible future cost increases.

In the absence of additional structures to support safety net providers, such as Medi-Cal rate increases, a county contribution under AB 8 cannot work. It would simply transfer funds from hospital systems already financially weakened by capped funds in spite of growing costs.

As counties seek to understand the potential impact of health care reform at the local level, they are looking to their public hospital systems to better understand potential costs and benefits. In order to help county Boards of Supervisors assess various health care proposals, it is critical that they are equipped with information on any proposed county contributions for health care reform. We therefore ask that any relevant information be shared with counties regarding a share of cost component.

- **Workable Provider Fee**

A provider fee should only be considered as part of a comprehensive reform package that includes full cost Medi-Cal rate increases for public hospital systems and an expansion of childless adults under an LCO model.

We are also concerned that the structure of premium assistance may jeopardize the health care safety net. Accordingly, we ask that these provisions be delayed, or structured in a way that ensures the continued viability of the Medi-Cal program.

Thank you for your consideration of these issues. We look forward to supporting a health care reform package that improves access to health care and supports all public hospital systems.

Sincerely,

Melissa Stafford Jones
President and CEO

William Walker, M.D.
Director and Health Officer
Contra Costa Health Services
Chair, CAPH Board

Doug Bagley
Chief Executive Officer
Riverside County Regional Medical Center
Chair-Elect, CAPH Board

Wright Lassiter III
Chief Executive Officer
Alameda County Medical Center
Secretary Treasurer, CAPH Board

Bruce Chernof, M.D.
Director & Chief Medical Officer
Los Angeles County Department of Health Services
Executive Committee Member, CAPH Board

Enclosure

cc: Kim Belshe, Secretary, California Health and Human Services Agency
Stan Rosenstein, Deputy Director, Department of Health Services
Herb Schultz, Senior Health Policy Advisor, Office of Governor Arnold Swarzenegger
Members of CAPH Board
Terri Thomas, Thomas Advocacy

GOVERNOR'S HEALTH CARE REFORM PROPOSAL - AGGREGATE IMPACT ON PUBLIC HOSPITALS

(CAPH INITIAL ANALYSIS)

DOLLARS IN MILLIONS

	WITHOUT LOCAL COVERAGE OPTION	WITH LOCAL COVERAGE OPTION
RATES & PROVIDER FEE		
Current Medi-Cal Population Rate Increases*	$ 949	$ 949
Provider Fee	(600)	(600)
Additional FFP From Provider Fee	150	150
IMPACT ACCORDING TO GOVERNOR'S 9/7/07 MEDIA STATEMENT	499	499
LOSSES & GAINS FROM COVERAGE, INCLUDING COUNTY SHARE OF COST		
Payments for newly covered/Reductions in uncompensated care.	1,558	1,829
County Share of Cost & Loss of DSH/SNCP Funding	(2,004)	(2,004)
TOTAL IMPACT	52	323

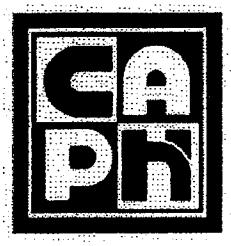
* Number provided by State DHCS; $599M originally in Governor's proposal, plus additional $350M to achieve full cost Medi-Cal rates.

• The Governor's Media Statement asserting that public hospitals will gain $500 Million under reform is incomplete and only looks at part of the picture. The impact of reform on public hospital systems involves several factors, all of which must be considered to determine the actual impact of reform on California's public hospital systems.

• As the chart above demonstrates, there would only be a gain of $52 Million even if public hospital systems are paid rates to cover the full Medi-Cal costs. This gain is insufficient to allow public hospital systems to be stable, viable and competitive under a reformed health system. Even with an additional $52 million in funding, public hospital systems would have over $1.5 Billion in unreimbursed costs. As a point of comparison, private hospitals will gain an estimated net benefit of $1.7 Billion under the Governor's reform proposal.

• In order for reform to be effective and ensure that all Californians are able to get the health care services they need, including the critical services provided by public hospital systems, such trauma, training, and specialty care, ALL components proposed by public hospital systems - including full cost Medi-Cal Rates and coverage of childless adults with exclusivity under a Local Coverage Option - must be included in a comprehensive reform package.

September 2007 Analysis from California Association of Public Hospitals and Health Systems



CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

CAPH Health Care Reform Position Paper
August 30, 2007

CAPH urges lawmakers to protect public hospital systems through structural mechanisms that ensure their meaningful participation in a reformed health care system. In order to accomplish this goal, the following amendments are needed in a health care reform package:

1. Medi-Cal Rates that Reflect the Full Cost of Providing Care: In order to continue providing high quality care and maintain essential services for their communities, public hospital systems must be compensated at the full cost of providing these services. Rates must be paid at current and future full costs in the following settings:
    - Inpatient fee for service;
    - Outpatient fee for service; and
    - Medi-Cal managed care

2. Local Coverage Options (LCO's) for Childless Adult Expansion: CAPH supports an expansion of a comprehensive reform package to include coverage of low-income childless adults. If such a program is implemented, these individuals should be enrolled exclusively in transitional, county-based coverage programs using a limited network of public hospital systems and community clinics, and other providers for medically necessary services that are not available through the aforementioned network of providers. Most counties would structure their LCO's in partnership with a Local Initiative, County Organized Health System or a county-administered Knox Keene product, or through a county-administered coverage program. Rates paid to providers under LCO's must reflect the full cost of treating this patient population. Exclusive enrollment for these beneficiaries would continue for at least five years, with an assessment based on the LCO's meeting certain performance benchmarks at the end of the third year.

   To support a transition to the LCO model, CAPH urges the Legislature to direct the State to seek $360 million in unspent Federal funds under the hospital financing waiver. These dollars would enable the State to begin the development of an LCO model in the final two years of the waiver, 2008-2010. If the $360 million in federal funds is not available, additional State dollars would be necessary for this transition.

3. Net Benefit to All Public Hospital Counties: A health care reform package that results in aggregate financial and structural gains for counties with public hospitals – but includes some significant losses for individual counties – is not sustainable. Each public hospital system must emerge from a reformed health care system adequately equipped to continue providing services to those who need it most.

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4. Financial Incentives for Local Initiatives (LI's)/County-Organized Health Systems (COHS's) within Purchasing Pool: Additional incentives should be offered to consumers within the purchasing pool to choose Medi-Cal managed care plans that were designed to support the safety net. These plans would agree to:

   1) Utilize public hospitals and their related public providers and community health centers to the maximum extent possible except with respect to those medically necessary services that are not available in the network of providers listed above; and

   2) Compensate public hospitals and related public providers for at least the full cost of providing services to their enrollees, pursuant to the Special Terms and Conditions of the hospital financing waiver.

5. A Reasonably Constructed County Share of Cost: A proposed county contribution is a difficult and potentially high risk proposition for public hospital systems that already operate under serious financial constraints. With State support for the health care safety net, through Medi-Cal rate increases and an expansion of coverage for childless adults under 100% FPL, a financial contribution from counties is possible, **ONLY IF** it is:
   - Retrospective so that counties are not asked to fund a system up-front based on projections;
   - Based on actual cost reductions with consideration of remaining fixed costs and the costs of treating those who remain uninsured; and
   - Structured in a way that takes into account both the State's need to fund a health care reform system and counties' need to respond to possible future cost increases.

   In the absence of additional structures to support safety net providers, such as Medi-Cal rate increases, a county contribution under the currently proposed health care reform legislation (AB 8) cannot work. It would simply transfer funds from hospital systems already financially weakened by capped funds in spite of growing costs.

6. Delay of Premium Assistance and Elimination of Redetermination Language: The proposed legislation mentioned in Number 5 above includes language that would implement a premium assistance system that requires Medi-Cal eligible workers to accept their employers' private insurance offering instead of traditional Medi-Cal benefits. This threatens to undermine an important patient base for public hospital systems. Therefore, CAPH urges the elimination of this language and the delayed implementation of premium assistance until a feasibility and impact study can assess its potential effect on the health care safety net.

7. A Workable Provider Fee: A provider fee must be part of a comprehensive reform package that includes full cost Medi-Cal rate increases for public hospital systems and an expansion of childless adults under an LCO model.